(2) the Hospital continues to fulfill its discharge planning duties as required in the Division's regulations;

(3) the patient continues to need acute level care and is therefore ***not*** on Administrative Day status on any day for which an outlier payment is claimed;

(4) the patient is not a patient in a Distinct Part Psychiatric Unit on any day for which an outlier payment is claimed; and

(5) the patient is not a patient in a Non-Acute Unit within an Acute Hospital.

10. Physician Payment

For physician services provided by Hospital-based physicians or Hospital-based entities to MassHealth patients, the Hospital will be reimbursed in accordance with, and subject to, the Physician Regulations at 130 CMR 433.000 et. seq. Such reimbursement shall be at the lower of the fee in the most current promulgation of the DHCFP regulations at 114.3 CMR 16.00 (Surgery and Anesthesia Services), 17.00 (Medicine), 18.00 (Radiology) and 20.00 (Clinical Laboratory Services)[1] (including the applicable facility fee for all services where such facility fee has been established), or the Hospital's usual and customary charge.

Hospitals will be reimbursed for such physician services only if the Hospital-Based Physician or a physician providing services on behalf of a Hospital-Based Entity took an active patient care role, as opposed to a supervisory role, in providing the Inpatient Service(s) on the billed date(s) of service. Physician services provided by residents and interns are reimbursed through the direct medical education (DME) portion of the SPAD payment and, as such, are not reimbursable separately. Hospitals will not be reimbursed separately from the SPAD and per diem payments for professional fees for practitioners other than Hospital-based physicians.

Hospitals shall not be reimbursed for inpatient physician services provided by Community-Based Physicians or Entities.

[1] The regulations referred to in this paragraph are voluminous, and will be provided upon request.

11. Payments for Administrative Days

Payments for Administrative Days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all Administrative Days in all Acute Hospitals.

The AD rate is a base per diem payment and an ancillary add-on.

The base per diem payment is $134.33, which represents the median calendar year 2002 nursing home rate for all nursing home rate categories, as determined by DHCFP

The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated separately for Medicaid/Medicare Part B eligible patients and Medicaid-only eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997 to September 30, 1998.

These ratios are 0.278 and 0.382, respectively. The resulting AD rates (base and ancillary) were then updated for inflation using the update factor of 2.226% for inflation between RY02 and RY03. RY03The resulting AD rates for RY03 are $175.40 for Medicaid/Medicare Part B eligible patients and $189.68 for Medicaid-only eligible patients.

A Hospital may receive outlier payments for patients who return to acute status from AD status after 20 cumulative acute days in a single hospitalization. That is, if a patient returns to acute status after being on AD status, the Hospital must add the acute days preceding the AD status to the acute days following the AD status in determining the day on which the Hospital is eligible for outlier payments. The Hospital may not bill for more than one SPAD if the patient fluctuates between acute status and AD status; the Hospital may only bill for one SPAD (covering 20 cumulative acute days), and then for Outlier Days, as described above.

12. Infant and Pediatric Outlier Payment Adjustments

a. Infant Outlier Payment Adjustment

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual infant outlier payment adjustment to Acute Hospitals for Inpatient Services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths-of-stay. Hospitals will be reimbursed by the Division pursuant to the DHCFP Regulations at 114.1 CMR 36.05(3)(d) (attached as **Exhibit 5**).

b. **Pediatric Outlier Payment Adjustment**

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual pediatric outlier payment adjustment to Acute Hospitals for Inpatient Services furnished to children greater than one year of age and less than six years of age if provided by a Hospital which qualifies as a disproportionate share Hospital under Section 1923(a) of the Social Security Act. (See Basic Federally Mandated Disproportionate Share Adjustment, **Section IV.D.2**, for qualifying Hospitals.) Hospitals will be reimbursed by the Division pursuant to the DHCFP Regulations at 114.1 CMR 36.05(3)(c)(attached as **Exhibit 5**).

13. **Rehabilitation Unit Services in Acute Hospitals**

A per diem rate for rehabilitation services provided at an Acute Hospital shall apply only to Acute Hospital rehabilitation units operating at Public Service Hospitals in order to meet any remaining service needs following closure of a public rehabilitation Hospital.

The per diem rate for such rehabilitation services will equal the average MassHealth RY03 rehabilitation hospital rate adjusted for inflation. This rate represents the average MassHealth RY03 rehabilitation Hospital rate, weighted by volume of days, after removing the two lowest rates rehabilitation hospitals from the average. Acute Hospital administrative day rates will be paid for all days that a patient remains in the rehabilitation unit while not at acute or rehabilitation hospital level of care.

Such units shall be subject to the Division's screening program for chronic and rehabilitation hospitals as detailed in 130 CMR 435.408 (attached as **Exhibit 5a**).

14. **Supplemental Payment: Interpreter Services**

The Division shall make a supplemental payment in addition to the standard reimbursement made under the Division's acute hospital contract, to recognize the costs to hospitals of training interpreters and providing interpreter services to MassHealth Members with Limited English Proficiency. Such lump sum payments are made annually. The payment amount will be (i) determined by the Division using data filed by each qualifying hospital in its financial and cost reports, and (ii) a percentage of the difference between the qualifying hospital's total Medicaid costs and total Medicaid payments from any source, which percentage shall in no event exceed 100 percent.

C. **Reimbursement for Unique Circumstances**

1. **Sole Community Hospital**

The RY03 standard inpatient payment amount per discharge for a Sole Community Hospital (as defined in **Section II**) shall be equal to the sum of:

95% of the Hospital's FY98 cost per discharge capped at 200% of the statewide average payment amount per discharge, adjusted for casemix and inflation; and the Hospital-specific RY03 pass-through amount per discharge and the capital amount per discharge.

Derivation of RY03 per-discharge costs is described in **Section IV.B.2.**

Adjustments were made for casemix by dividing the FY98 cost per discharge by the Hospital's FY98 all-payer casemix index and then multiplying the result by the Hospital's MassHealth casemix index. To develop the Hospital's RY03 casemix index, the Division used casemix discharge data submitted to DHCFP by the Hospital, as accepted into DHCFP's database as of July 22, 2002, for the period October 1, 2000, through September 30, 2001, which was then matched with MassHealth SPAD and transfer claims for the same period to ensure that only MassHealth claims were included in the final casemix calculations. The casemix data did not include discharges from Excluded Units.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 1.9% to reflect inflation between RY98 and RY99, by 1.43% to reflect inflation between RY99 and RY00, by 2.4% to reflect inflation between RY00 and RY01; by 1.152% to reflect inflation between RY01 and RY02; and by 2.226% to reflect inflation between RY02 and RY03.

There will also be outlier payments for patients whose length of stay during a single Hospitalization exceeds twenty acute days.

Acute Hospitals which receive payment as Sole Community Hospitals shall be determined by the Division.

2. **Specialty Hospitals and Pediatric Specialty Units**

The standard inpatient payment amount per discharge for Specialty Hospitals and Hospitals with Pediatric Specialty Units (as defined in **Section II**) shall be equal to the sum of:

95% of the Hospital's FY98 cost per discharge capped at 200% of the statewide average payment amount per discharge, adjusted for casemix and inflation; and the Hospital-specific FY03 pass-through amounts per discharge and the capital amount per discharge.

Derivation of RY03 per discharge costs is described in **Section IV.B.2.**

Adjustments were made for casemix by dividing the FY98 cost per discharge by the Hospital's FY98 all-payer casemix index and then multiplying the result by the Hospital's MassHealth casemix index.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 1.9% to reflect inflation between RY98 and RY99, 1.43% to reflect inflation between RY99 and RY00, by 2.4% to reflect inflation between RY00 and RY01; by 1.152% to reflect inflation between RY01 and RY02; and by 2.226% to reflect inflation between RY02 and RY03. RY03

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute Hospitals that receive payment as Pediatric Specialty Hospitals and Pediatric Specialty Units shall be determined by the Division.

For Hospitals with Pediatric Specialty Units, the payment amount calculated under this section shall only apply to services rendered in the Pediatric Specialty Unit.

3. **Public Service and Municipal Hospital Providers**

a. **Inpatient Reimbursement**

Public Service and Municipal Hospitals shall be reimbursed for Inpatient Services as follows, and in accordance with **Section IV.C.3.b**. The standard inpatient payment amount per discharge for Public Service and Municipal Hospital providers (as defined in **Section II**) shall be equal to the sum of:

95% of the Hospital's FY98 cost per discharge capped at 200% of the statewide average payment amount, adjusted for casemix and inflation; and the RY03 Hospital-specific pass-through amount per discharge and the capital amount per discharge.

Derivation of RY03 per discharge costs is described in **Section IV.B.2**.

Adjustments were made for casemix by dividing the FY98 cost per discharge by the Hospital's FY98 all-payer casemix index and then multiplying the result by the Hospital's MassHealth casemix index. To develop the Hospital's RY03 casemix index, the Division used casemix discharge data submitted to DHCFP by the Hospital, as accepted into DHCFP's database as of July 22, 2002, for the period October 1, 2000, through September 30, 2001.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 1.9% to reflect inflation between RY98 and RY99, by 1.43% to reflect inflation between RY99 and RY00, by 2.4% to reflect inflation between RY00 and RY01, by 1.152% to reflect inflation between RY01 and RY02, and by 2.226% to reflect inflation between RY02 and RY03.

There will also be outlier payments for patients whose length of stay during a single Hospitalization exceeds twenty acute days

Acute Hospitals that receive payment as Public Service or Municipal Hospitals shall be determined by the Division.

b. **Municipal Acute Hospital Providers**

Municipal Acute Hospitals that do not also qualify as Public Service Hospitals shall be reimbursed in accordance with **Sections IV.B** and **IV.C.3.c.** herein.

c. **Supplemental Payment**

Subject to the availability of federal financial participation, the Division shall make a supplemental payment in addition to the standard reimbursement made under the Division's Acute Hospital Contract, to recognize Public Service and Municipal Acute hospitals' extraordinary costs of serving MassHealth members. Such lump sum payments are made annually at the end of the applicable fiscal year, or at such other times as the Division may determine. The payment amount will be (i) determined by the Division using data filed by each qualifying hospital in its financial and cost reports, and (ii) a percentage of the difference between the qualifying hospital's total Medicaid costs and total Medicaid payments from any source, which percentage shall in no event exceed 100 percent.

Acute hospitals that receive payment as public service hospital and municipal acute hospital providers shall be determined by the Division.

4. **Non-Profit Teaching Hospitals Affiliated with a Commonwealth-Owned Medical School**

a. Subject to **Section IV.C.4.b**, the inpatient payment amount for non-psychiatric admissions at non-profit acute care teaching Hospitals affiliated with a Commonwealth-owned medical school shall be equal to the Hospital's cost per discharge calculated as follows. The data used for this payment will be from the most recent submission of the Hospital's or predecessor Hospital's DHCFP-403 report(s).

Total Hospital-specific inpatient non-psychiatric charges are multiplied by the Hospital's inpatient non-psychiatric cost-to-charge ratio (calculated using DHCFP-403, Schedule II, column 10, line 100 minus column 10, line 82 for the total cost numerator and schedule II, column 11, line 100 minus column 11, line 82 for the total charges denominator) to compute that facility's total inpatient non-psychiatric cost. The total inpatient non-psychiatric cost is then multiplied by the ratio of the Hospital-specific non-psychiatric MassHealth discharges to the total Hospital non-psychiatric discharges to yield the MassHealth inpatient non-psychiatric cost. The MassHealth inpatient non-psychiatric cost is then divided by the number of MassHealth non-psychiatric discharges to calculate the MassHealth cost per discharge. This MassHealth cost per discharge is multiplied by the inflation rates for those years between the year of the cost report and the current rate year, as set forth in **Section IV.B.2.**

b. Any payment amount in excess of amounts which would otherwise be due any non-profit teaching Hospital affiliated with a state-owned medical school pursuant to **Section IV.B** is subject to specific legislative appropriation.

5. Essential MassHealth Hospitals (Effective 1/20/01)

a. Qualifications

In order to qualify for payment as an Essential MassHealth Hospital, a Hospital must meet at least four (4) of the following criteria, as determined by the Division:

(1) The Hospital is a non-state-owned public acute Hospital.

(2) The Hospital meets the current MassHealth definition of a non-profit teaching hospital affiliated with a commonwealth-owned medical school.

(3) The Hospital has at least 7% of its total patient days as Medicaid days.

(4) The Hospital is an acute care general hospital located in Massachusetts which provides medical, surgical, emergency and obstetrical services.

(5) The Hospital enters into a separate contract with the Division relating to payment as an Essential MassHealth Hospital.

b. Reimbursement Methodology

(1) Subject to specific legislative authorization and appropriation and compliance with federal upper payment limit and other applicable regulations at 42 CFR Part 447, the Division will make a supplemental payment in addition to the standard reimbursement made under the Division's Acute Hospital Contract, to Essential MassHealth Hospitals. Such lump sum payments are made annually at the end of the fiscal year, or at such other times as the Division may determine. The payment amount will be (i) determined by the Division using data filed by each qualifying hospital in its financial and cost reports, and (ii) a percentage of the difference between the qualifying hospital's total Medicaid charges and total Medicaid payments from any source, which percentage shall in no event exceed 100 percent.

6. MassHealth Critical Access Hospitals (Effective 3/3/01)

a. Qualifications

In order to qualify for payment as a MassHealth Critical Access Hospital, a Hospital must meet all of the following criteria, as determined by the Division:

(1) The Hospital is currently an acute Hospital located and licensed in the Commonwealth of Massachusetts

(2) The Hospital participates in the MassHealth program pursuant to the Division's Acute Hospital RFA

(3) The Hospital demonstrates financial need, as evidenced by (a) negative operating margin; (b) insufficient cash flow; or (c) decreasing fund balance.

(4) The Hospital demonstrates actual or potential loss or reduction in critical medical services to MassHealth Members (i.e., obstetric, psychiatric and emergency services) based on the following information for each type of service: (a) the total number of patients who used the service in FY00 and FY01; (b) the number of MassHealth Members who used the service in FY00 and FY01; (c) the number of units of service provided to MassHealth Members in FY00 and FY01; and (d) the availability of the same or similar services within a 25 mile radius.

(5) The Hospital's current likelihood of continued Hospital operations, evaluated based on: (a) the minimum additional reimbursement the Hospital must receive in order to maintain access to critical medical services for MassHealth Members at the levels currently provided; (b) the Hospital's current plans for closing facilities that currently serve MassHealth Members, or of terminating services currently used by MassHealth Members; and (c) the causes of the Hospital's financial distress.

b. Reimbursement Methodology

Subject to specific legislative appropriation and compliance with federal upper payment limit regulations at 42 CFR Part 447, the Division will reimburse a MassHealth Critical Access Hospital based on the following methodology:

First, each Hospital that applies for reimbursement as a MassHealth Critical Access Hospital is assigned a numerical financial distress rating based upon the Hospital's demonstrated financial need. Second, each applicant Hospital is assigned a numerical rating based upon the loss of access to critical medical services and the current likelihood of continued hospital operations. Based upon these ratings, hospitals are given an overall score and ranked. Available funds appropriated for this purpose are then allocated to the top ranking Hospitals and distributed based upon the greatest financial need, most serious access issues, the reimbursement amount needed to restore or ensure MassHealth Members' continued access to critical services, and in amounts likely to achieve the greatest public health impact.

The reimbursement to MassHealth Critical Access Hospitals referenced above is in addition to the reimbursement otherwise payable to such Hospitals pursuant to **Section IV.B and C**. Total payments to a MassHealth Critical Access Hospital (excluding disproportionate share hospital payments) shall not exceed the Hospital's customary charges to the general public.

D. Classification of Disproportionate Share Hospitals (DSHs) and Payment Adjustments

MassHealth will assist Hospitals that carry a disproportionate financial burden of caring for uninsured and publicly insured persons of the Commonwealth. In accordance with Title XIX rules and requirements, MassHealth will make an additional payment to Hospitals which qualify for such an adjustment under any one or more of the classifications listed below. Only Hospitals that have an executed Contract with the Division, pursuant to the RY03 RFA, are eligible for disproportionate share payments since the dollars are, in most cases, apportioned to the eligible group in relation to each other. MassHealth-participating Hospitals may qualify for adjustments and may receive them at any time throughout the Rate Year. If a Hospital's RFA Contract is terminated, its adjustment shall be prorated for the portion of RY03 during which it had a Contract with the Division. The remaining funds it would have received shall be apportioned to remaining eligible Hospitals. The following describes how Hospitals will qualify for each type of disproportionate share adjustment and the methodology for calculating those adjustments.

In accordance with federal and state law, Hospitals must have a MassHealth inpatient utilization rate of at least 1% to be eligible for any type of DSH payment, pursuant to DHCFP regulation at 114.1 CMR 36.07 (see **Exhibit 6**). Also, the total amount of DSH payment adjustments awarded to any Hospital shall not exceed the costs incurred during the year of furnishing Hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third-party coverage, less payments received by the Hospital for medical assistance and by uninsured patients ("unreimbursed costs"), pursuant to 42 U.S.C. §1396r-4(g). In accordance with the requirements of 42 U.S.C. 1396r-4(b)(2) and (3), Medicaid inpatient utilization rate and low-income utilization rate include both Medicaid fee-for-service and managed care entity days and revenue for patient services under the State Plan, as applicable.